# Here Come the Ethicists!

**by Giles R. Scofield, J.D.**

Clinical ethics has come of age. It has grown from a fledgling field into an industry. There now exist many centers, in academic and other settings, dedicated to studying, discussing and educating others about medical ethics. The Society for Health and Human Values, the American Society for Law, Medicine and (now) Ethics, and the American Association of Bioethics are competing with one another for the support and sponsorship needed to be regarded as the dominant, legitimate voice in clinical ethics. Programs offering some form of concentration or certificate in clinical ethics are springing up at various schools.

One group that has benefitted from (and encouraged) the prominence of clinical ethics are clinical ethicists. These individuals secure grants and donations to write about important issues, advise government at all levels, staff panels, and author studies on this or that topic. Some of them even appear in the media, offering an opinion on everything from the activities of Jack Kevorkian to the fate of frozen embryos.

By all accounts, ethics is big business. One aspect of this business is ethics consultation. Ethics consultants are individuals who provide ethics consultations in hospitals, practicing "bedside ethics." Physicians, patients and families are the intended beneficiaries of the ethics consultant's effort to "help" them decide what ought to be done in a given situation. One reason that ethics consultation is expanding is because the Joint Commission for the Accreditation of Health Care Organizations now requires that all hospitals have a mechanism in place for addressing ethical issues in patient care. This change has made hospitals take ethics seriously. And because no hospital wants to get a bad mark on its ethics program, every hospital searches for the help it needs to satisfy JCAHO surveyors. Ethics consultants are a source of salvation to many such institutions.

As a result, some individuals are cashing in on the knowledge and expertise they possess in clinical ethics, arranging deals that range from salaried positions to fee-for-service ethics. Not surprisingly, now that there is money to be made in ethics, questions are arising on who ought to be allowed to earn a living in this manner. Thus, at the same time that programs spring up offering certification in clinical ethics, which gives academic centers and programs a vested interest in this enterprise, clinical ethicists themselves are wondering aloud about such matters as accreditation and credentialing. The public, it seems, needs to be protected against moral snake oil.

All of this has led to questions about the professionalization of ethics consultation, which I have examined elsewhere.[1] Basically, I doubt that ethics consultation is or ought to be a profession. What is its body of knowledge and skills? Assuming such a body of knowledge and skills exist, can anyone master it? If so, what is the test for possessing ethical expertise? How does one cram for the exam in empathic understanding? Even if one can master these skills and knowledge, where's the proof that they can be applied objectively? Is it true that subjective considerations do not affect the work ethics consultants do? Are ethics consultants so conscientious that they can be trusted to police themselves? Should we be concerned about how they are remunerated? Will they act in the public interest and not out of self-interest?

Finally, how do ethics consultants reconcile belief in their superior knowledge and skills in ethics with the fundamental belief of a democratic society, which is that each person should be regarded as the moral equal of every other? If the moral domain is supposed to be everyone's business, how can ethics consultants make any of it their exclusive business? Is it true that no one else can know what they know without the benefits of a graduate education?

Although asking questions is supposed to be what ethicists enjoy doing, I have to say that a number of ethicists have not found pleasure in these questions. In fact, a few of them have told me they don't share my concerns and think I could be asking these questions differently. In other words, they don't like the fact that anyone is questioning what they are doing and whether their conduct is morally and politically justifiable. This from a field that prides itself on the inherent value of self-examination. Not only do some clinical ethicists not want to examine the questions that the prospect of their professionalization creates, they want to keep their plans secret. Exactly who or what these individuals are afraid of is something of a mystery.

Before advancing the discussion, I want to dispose of two criticisms that have been made. The first comes from Professor John C. Fletcher, who directs the Center for Biomedical Ethics at the University of Virginia and serves on the board of the Society for Bioethics Consultation (SBC). In a recent issue of the SBC newsletter,

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Professor Fletcher said that he knew of no arguments for a new profession of clinical ethics, and that clinical ethicists do not aspire to be a new profession. In short, he thinks my concerns about the professionalization of ethics consultation are a "man (sic) of straw," made to be easily refuted. On the question of whether any arguments are being made in favor of the professionalization of ethics consultation, we would all likely benefit from the opportunity to know the workings of a task force on which Professor Fletcher serves and the wording of a proposal over which the task force is struggling. In the Winter 1993 SBC newsletter, there is an announcement that the SBC and the Society for Health and Human Values have formed a task force to study "Standards for Clinical Ethics Education and Consultation." At the SBC's 1993 annual meeting I was on a panel convened for the purpose of discussing issues this task force may have to address. Although I was provided with a copy of a draft of the proposal to set up this task force, I was asked to keep its contents private. On the one hand, then, some of the leaders of the SBC are making public statements that no one in the field is talking about turning ethics consultation into a profession, while simultaneously keeping private documents that might shed light on what is actually being said and done about this issue.

However much the public and the members of the SBC might benefit from an open airing of what the SBC/SHHV task force is up to, it is still fairly easy to dismiss the statement that no clinical ethicist wants to turn ethics consultation into a new profession. At the SBC's annual meeting, the membership approved the minutes of the 1992 meeting, which evidently are not intended to be kept secret. In those minutes the President's Report for the 1993 year includes the following goal: "Maintain the SBC in the process of the professionalization of ethics consultation."[2]

The second criticism is that ethics consultants do not need a code of ethics. Such a view suggests that neither ethics consultants nor their clients need to be concerned about the following matters: What ought to be done about the incompetent or impaired ethicist? What ought to be done about the ethics consultant who engages in sexual misconduct with a client? What are the ethics of marketing oneself as an ethics consultant? What are the ethics of making referrals or of sharing fees? Even though it seems that clinical ethicists have avoided dealing with business issues in the institutional setting,[3] that does not mean that such issues are not likely to be of importance to their clients.

## Cutting to the chase

Instead of belaboring the obvious or denying the truth, it would be helpful if we could move the discussion about the professionalization of ethics consultation to a meaningful level. One scholar who has attempted to do this is Professor Margaret Urban Walker. In a recent article,[4] Professor Walker agrees with the concerns some have raised about the notion that ethics consultants have some sort of moral expertise. She rejects the idea that they ought to be regarded as experts or engineers who can "fix" dilemmas. Instead, she proposes that they be treated as architects and mediators, individuals whose purpose is to keep the moral space open and the conversation free-flowing.

I suspect no one could have anything against keeping moral spaces open or ensuring that conversations are wide-ranging. Before accepting this as the ethics consultant's role, however, we need to ask a few questions.

To begin with, architects, like engineers, are professionals. This means that they are believed and supposed to possess a definite body of knowledge and skills that others do not. This begs the question already asked of ethics consultants: What is it they know and do that others do not and cannot. It also forces us to ask again how objective that knowledge and those skills are, and whether subjective concerns do not influence how ethics consultants do what they do.

Second, architects do not create space; they create enclosures. The space is less open after the architect has fenced it in. If ethics consultants are architects, how do they separate what is inside from what is outside our supposedly open moral space? Does the wall they create keep certain types of knowledge outside? What sort of enclosure can be open to all yet closed to some at the same time? Instead of keeping the moral domain open, aren't ethics consultants fencing it in? If there is no such thing as the view from nowhere, how can there be a space from nowhere?

Other questions can be raised about the ethics consultant's role as mediator. This sounds like a neutral, objective role, but it isn't. It is impossible to mediate a discussion without affecting, even influencing, it. Indeed, the only way that ethics consultants can persuade others of their value is through acceptance of the belief that these conversations will be different, i.e., better, if the consultant is involved. Regardless of whether we think that ethics consultants ought to be mediators, we should not delude ourselves into thinking that they do not, cannot or will not influence how others discuss and deliberate ethical dilemmas.

The suggestion that ethics consultants should be mediators presupposes two things. The first is that they can do this; the second is that others cannot. I know of no study that establishes that all ethics consultants possess the intellectual rigor and emotional resilience needed to mediate a conference about a dying patient. Even if some ethics consultants can do this, that does not mean others cannot. Are we to believe that no social worker, chaplain or psychiatric liaison nurse has got what it takes to do this?

Finally, making the ethics consultant's role seem innocuous

does not make it any less offensive to our basic democratic values. The distinction between being an engineer and being an architect is fairly arbitrary and hardly eliminates the question of moral expertise implicit in the ethics consultant's claim. In addition, conversational expertise is hardly a benign claim. If consent is the essence of a democracy, and conversation is the essence of consent, then the ethics consultant's claim is that some individuals know better than others what needs to be said and how conversations ought to proceed.

These are only some of the questions that the professionalization of ethics consultation creates. Others concern the legal liability of ethics consultants. If architects can commit malpractice, then so can ethics consultants. If ethics consultants are to be reimbursed, what constitutes a reasonable and necessary charge? Who will review the ethicist's charges? And on what basis? Finally, if a hospital enters into an exclusive contract with an ethics consultant or the SBC decides to accept or make referrals only from and to qualified individuals, what are the antitrust implications? If these questions sound ludicrous, that is because there is something deeply troubling about making ethics a field for entrepreneurs, and about turning ethics into a field that one enters not for the pursuit of truth, but for the pursuit of wealth.

## Just what is going on here?

If we are to come to terms with what ethics consultants are doing, we have to get past the obfuscation that plagues most discussions of ethics consultation. To do that, we need first of all to see that the ethics consultant's claim of expertise is a simple one. It is to be an expert at legitimation. This means that ethics consultants, like many other intellectuals, serve to create and sustain the social construction of morality. They write and talk about the values that form the basis of our society and they struggle with how those values can be reconciled to the decisions we make.

This is an essential role in every society. The difficulty with experts at legitimation is that it is difficult, if not impossible, for them to separate questions about how the world is from questions about how it ought to be. When they cross that line, they become experts at normality. In this capacity they become agents of social control, bringing a sense of discipline to the seemingly chaotic world of moral discourse.

In this second sense, the ethics consultant is a disciplinary force, whose purpose is the regimentation of the moral imagination. In the same ways that society has developed institutions and personnel to govern our penal, medical, psychological and sexual propensities, the emergence of ethical discord has created the need to bring ethical discourse under control. Free-range ethics, it seems, is a threat to society. We need enclosures to protect us and society from the winds that challenge our view of how the world ought to be. We need ethics consultants to hold things together.

Do we? Can we afford to create such a profession? Can we be sure that acceptance of the ethics consultant's claim to be a professional will not diminish, if not end, lay ethical analysis? If the acceptance of professional authority entails a surrender of judgment, just what do we surrender to ethics consultants if we accept their claim of expertise?

Within a democratic society, it is difficult to define, much less hold, the line that separates an expert at legitimation from an expert at normality, especially if the moral domain, which encompasses issues of "is" and "ought," is supposed to be open to everyone. At bottom, that is the difficulty I perceive in finding a suitable role for the clinical ethicist in our society. For clinical ethicists to behave in a politically responsible manner,[5] they must act in ways that further our democratic ideals and avoid acting in ways that subvert such aspirations. That is difficult to do, especially for individuals who hold strong, well-considered viewpoints on how things ought to be.

The difficulty is that we all hold and are entitled to hold equally strong opinions on how things ought to be, which means that we should not and must not allow any individual or group to possess or wield the sort of power that creates inequalities on the moral playing field. It is for reasons such as these that I have concluded the role for the clinical ethicist that is most consistent with and least offensive to the ideals of a genuinely democratic society is that of educator. Beyond that, the ethicist comes too close to crossing the line that separates an expert at legitimation from an expert at normalization.

Such a role is hardly minimal. Education can occur in many settings. Teaching can be done before, during and after an ethical dilemma. And what it means to be an educator in democratic society raises tensions that do not exist in other political arrangements. Of course, to accept this role is to accept the limits it imposes. It will do no good for clinical ethicists to claim they are educators, if what they are doing includes activities that move well beyond the field of education.

I know all too well how unacceptable this view is to some clinical ethicists, especially those who have invested considerable time and energy into pursuing this profession. And I know as well how many patients, families, physicians, nurses and ethics committees need the sort of help that clinical ethicists can offer. Misinformation and misconception dominate clinical decision-making. What we need to ask ourselves is whether the solution to this problem lies in allowing some to monopolize their knowledge, or in seeing to it that they share it with others.

The age of reason began with the belief that knowledge, as opposed to faith, is a source of power. Michel Foucault has, in many works, shown the ways in which knowledge can be used to obtain power and dominion. The opening sentence of Paul Starr's classic work on the rise of the medical profession is "The dream of reason

did not take power into account."[6] In all societies, most especially democracies, the basic political question is how to limit power and to hold those who are in a position to exercise power responsible and accountable to others. Where ethics consultation is concerned, we need to decide whether ethics consultants will define the sort of society we are, or whether the sort of society we are defines the role they may play.

## Endnotes

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In addition to unique personalities, the fellows each have a professional identity that makes its presence known quickly in several ways. Their language, the contextual parameters they use for analysis of clinical dilemmas and problems, their decision- making methodology and the resources they are accustomed to using reveal their professional backgrounds, methodologies and even the myths associated with being a physician, nurse, lawyer, theologian, philosopher, clergy and allied health professional.

Although it is difficult to avoid stereotypes in describing the professional identities and roles of the CCF Fellows, they clearly brought methodologies, roles and identities that reflected their profession. Lawyers were interested in the legal precedents, due process, documentation, argumentation and liability; the medical professionals were interested in the medical "facts" of the case, the therapeutic options available, the politics of clinical practice; clergy were interested in the "spiritual" dimensions of a case or the religious convictions that surfaced in the interplay among the parties to a case; allied health persons were interested in the social and psychological components of the case; nurses were interested in communication issues, advocacy for patient rights, the identification of the decision maker, etc.

The CCF fellowship curriculum is challenged by this Tower of Babel: how to ensure that everyone is using the same song book and not only singing from the same page, but also in the same key or at least harmoniously. The curriculum centers on establishing a common language of ethical decision-making, learning the ethics literature and appreciating the languages of the above-mentioned professions. It also assists the development or refinement of interpersonal skills such as teaching, interviewing, negotiating and communicating effectively both verbally and in writing.

The central theme that binds all the fellows is the concern for the proper care of the patient and the justification of the standards by which this care is evaluated ethically. The goal of the curriculum is to produce a person who retains his/her professional identity as a physician, nurse or lawyer; but who has also broadened his/her ability to engage in clinical bioethics discussions, who has a command of ethical language and literature and has the ability to teach effectively in a clinical environment.

## Conclusions

A hallmark of professional identity is the possession of esoteric knowledge and honed skills. If CBCs are to be considered professionals by this standard, they should demonstrate possession of esoteric knowledge such as a command of ethics methodology, language and literature as well as demonstrate skills of teaching, interviewing, negotiating and communicating under conditions of stress where the stakes are high.

CBCs are experiencing what some young professionals in other fields experience when they graduate into the world of professional activity. They face issues and questions that their mentors acknowledge are still unsolved or addressed inadequately. They are equipped with knowledge and skills to engage these and other unanticipated questions in a creative way that eventually may lead to new occupations and even professional groups. There are many examples in medicine: the development of medical, surgical and neurosurgical intensive-care physicians, the cardiology electro-physiologist, the vascular angioplasty surgeon, the pulmonary vascular angioplasty interventionalist.

A reasonable conclusion is that CBEC is a partially baked pie that needs to remain in the oven a bit longer. The issue of developing standards for CBEC is being addressed by SBC; but the issues of seeking public recognition and the issue of a code of behavior are not yet on its agenda.

## Endnotes

1.Schaefer RT. *Sociology*. New York: McGraw Hill, 1992, p.96

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